INSTRUCTIONS FOR:

TRICARE® Other Health Insurance Questionnaire

East Region

Privacy Act Statement	
This statement serves to inform you of the purpose for collecting your personal information through a *TRICARE Other Health Insurance Questionnaire* and how that information will be used.	
Authority:	10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.
Purpose:	To collect information from you in order to process your TRICARE medical claims under your TRICARE insurance and coordinate payment activities with other health insurance that may be available to you or members of your family.
Routine uses:	Your records may be disclosed to the federal and state agencies and to other health insurers in order to coordinate your benefits and payments for health care received. Use and disclosure of your records outside of the Deparment of Defense (DoD) may also occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the Health Insurance Portability and Accountability Act Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and health care operations.
Disclosure:	Voluntary. If you choose not to provide this information, no penalty may be imposed, but failure to provide the requested information may result in the delay or denial of payments and claims.

Submit Questionnaire		
Note: An incomplete questionnaire may result in a claims payment delay. Questions? Call 1-800-444-5445	**Mail questionnaire to:** Humana Military P.O. Box 740061 Louisville, KY 40201-7461	**Fax questionnaire to:** 1-866-836-9535

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OHI Questionnaire Form Instructions

1, General Information

TRICARE Sponsor Name: Fill in the TRICARE Sponsor name

Sponsor's Social Security Number or Department of Defense Benefits Number: Fill in either the Sponsor number (9 digits) OR the DoD Benefits Number (11 digits). The DoD Benefits number can be found on the back of the newer Military IDs.

Do you or any of your family members currently have Other Health Insurance (OHI) coverage? Select 'Yes' if you or any of your family members currently have OHI coverage

Have you or any of your family members had OHI coverage in the past 12 months? Select 'Yes' if you or any of your family members have had OHI coverage in the last 12 months

2: Primary OHI Status (Do NOT include TRICARE).

Policy Holder Name: Name of your insurance company

Policy number: Enter the policy number of the plan. This can usually be found on your insurance card.

Group/Plan number: Enter the Group/Plan number of the plan. This can usually be found on your insurance card.

Carrier Address and Phone #: Enter the address and phone number of your insurance company. This is usually given somewhere on your insurance card. For Medicare, this is only needed if you have a Medicare Advantage/Replacement plan.

Type of plan: Select the type of insurance plan (explanation of plans below)

- HDHP/HMO/PPO (Non-Medicare Plan) - Includes High Deductible Health Plan (HDHP), Health Maintenance Organization (HMO) or a Preferred Provider Plan (PPO) that is **not** a Medicare plan. This includes Medicare supplemental plans, which are plans purchased to pay additional benefits after traditional Medicare pays.
- Medicare - Includes standard Medicare Part A and/or Medicare Part B coverage.
- Medicare Advantage/Replacement Plan - Includes all forms of Medicare Advantage/Replacement plans, including Medicare HMOs, Medicare PPOs, and Medicare Cost Plans, that are approved by Medicare to administer Medicare benefits. They replace standard Medicare coverage. (Do NOT use for Medicare supplement plans.)
- TRICARE Supplemental - Plan that pays after TRICARE
- Medicaid/MediCal - State Medicaid plan
- Student Health Plan - Health plan that is provided while you are enrolled in college or through a school.
- Other - If your plan is not listed above, please provide the type of plan.

Does this coverage include pharmacy benefits? Does this plan cover prescription medications?

Does this coverage have benefit exclusions or limitations? Does your policy limit the types of services provided? Some examples would be cancer coverage only, or no heart disease coverage, etc. If you check 'YES', indicate what services are excluded or limited.

Name of Covered Member: Enter the first and last name of the person(s) covered by this plan.

Member ID: Enter the member ID of the person(s) covered by this plan.

Date of Birth: Enter the date of birth of the person(s) covered by this plan.

Gender: Enter the gender of the person(s) covered by this plan.

Effective Date: Enter the date the policy became effective for this person(s).This will be the original effective date of the policy. For Medicare this is usually the first of the month of your birthday month.

Expiration Date: If you no longer have this coverage enter the date the policy expired. If the coverage is still in effect, write "current".

3: Additional OHI Status (Do NOT include TRICARE).

If you have more than one OHI Policy, enter the information in this section. You would follow the same instructions as given in 2.If you have more than two OHI, include an additional sheet with the additional insurance information and attach to this form. Provide the same information as given in 2.

4 - Prior OHI Status (Do NOT include TRICARE).

Complete only if you or any of your family members have had OHI within the last 12 months that is no longer effective. You would follow the same instructions as given in 2.

Read the consent information and if you agree fill in the following information.

Your Signature: Sign your name.

Relationship to Sponsor: Fill in your relationship to the sponsor. The sponsor is the person who served in the Military.

Date: Fill in the date you signed the form.

TRICARE Other Health Insurance Questionnaire

Humana Military

1 - General Information

TRICARE Sponsor Name: _____

Sponsor's Social Security Number or Department of Defense Benefits Number: _____

Do you or any of your family members currently have Other Health Insurance (OHI) coverage? ☐ Yes ☐ No

Have you or any of your family members had OHI coverage in the past 12 months? ☐ Yes ☐ No

If you answered yes to either question above, please complete the remainder of the questionnaire (duplicate the questionnaire for multiple policies). Regardless of your answers above, please read and sign the questionnaire at the bottom and submit the questionnaire to the address or fax number provided on page 1.

2 – Primary OHI Status - Complete only if you or any of your family members currently have OHI.

Policyholder name: _____ Policy number: _____ Group/Plan number: _____

Name of carrier: _____ Effective date: _____ Expiration date: _____

Carrier address and phone number: _____

Type of Plan: ☐ HDHP/HMO/PPO (Non-Medicare Plan) ☐ Medicare ☐ Medicare Advantage/Replacement Plan ☐ TRICARE Supplemental
☐ Medicaid/MediCal ☐ Student Health Plan ☐ Other _____

Coverage is through: ☐ Employer ☐ Spouse ☐ Private ☐ School ☐ Government

Does this coverage include pharmacy benefits? ☐ Yes ☐ No

Does this coverage have benefit exclusions or limitations? ☐ Yes ☐ No If Yes, please indicate which one(s): _____

Name of covered member:	**Member ID:**	**Date of birth:**	**Gender:**	**Effective date:**(if different)	**Expiration date:**(if different)

3 – Additional OHI Status - Complete only if you or any of your family members currently have any additional OHI.

Policyholder name: _____ Policy number: _____ Group/Plan number: _____

Name of carrier: _____ Effective date: _____ Expiration date: _____

Carrier address and phone number: _____

Type of Plan: ☐ HDHP/HMO/PPO (Non-Medicare Plan) ☐ Medicare ☐ Medicare Advantage/Replacement Plan ☐ TRICARE Supplemental
☐ Medicaid/MediCal ☐ Student Health Plan ☐ Other _____

Coverage is through: ☐ Employer ☐ Spouse ☐ Private ☐ School ☐ Government

Does this coverage include pharmacy benefits? ☐ Yes ☐ No

Does this coverage have benefit exclusions or limitations? ☐ Yes ☐ No If Yes, please indicate which one(s): _____

Name of covered member:	**Member ID:**	**Date of birth:**	**Gender:**	**Effective date:**(if different)	**Expiration date:**(if different)

TRICARE Other Health Insurance Questionnaire

4 - Prior OHI Status - Complete only if you or any of your family members have had OHI within the last 12 months.

Policyholder name:_____ Policy number:_____ Group/Plan number:_____
Name of carrier:_____ Effective date:_____ Expiration date:_____
Carrier address and phone number: _____
Type of Plan: ☐ HDHP/HMO/PPO (Non-Medicare Plan) ☐ Medicare ☐ Medicare Advantage/Replacement Plan ☐ TRICARE Supplemental
☐ Medicaid/MediCal ☐ Student Health Plan ☐ Other _____
Coverage is through: ☐ Employer ☐ Spouse ☐ Private ☐ School ☐ Government
Does this coverage include pharmacy benefits? ☐ Yes ☐ No
Does this coverage have benefit exclusions or limitations? ☐ Yes ☐ No If Yes, please indicate which one(s):_____

Name of covered member:	**Member ID:**	**Date of birth:**	**Gender:**	**Effective date:**(if different)	**Expiration date:**(if different)

The statements made above are true and correct to the best of my knowledge. I understand that federal laws 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting or making false, fictitious, or fraudulent statements or claims in any matter within jurisdiction of any department or agency of the United States. I further understand that copies of the laws cited may be obtained from uniformed services legal offices, public libraries, and many Beneficiary Counseling and Assistance Coordinators.

_____ _____ _____
Your signature **Relationship to TRICARE Sponsor** **Date**